**Release of Information Consent Form**

1.PATIENT INFORMATION

Patient Full Name:

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. I AUTHORIZE:

Dr. Scott Conkright  
400 Plasters Ave NE, Suite 150  
Atlanta, GA 30324

Phone: 404-315-7150 Fax: 801-315-7150

To release and exchange information with the following person/organization:

3. ORGANIZATION/INDIVIDUAL INFORMATION

Organization Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And/or Person Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. INFORMATION TO BE RELEASED  
Specific dates/years of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All health information (excludes information from a chemical dependency program & psychotherapy notes)  
OR indicate the specific categories to be released:  
Diagnosis Psychological Evaluations Discharge Summary  
Treatment Plans Social History Provider/Hospital Records  
School/Criminal Records Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. PURPOSE FOR DISCLOSURE: Coordination of Care   
6. I UNDERSTAND THAT:  
§ My health information is protected by federal regulation (Alcohol & Drug Abuse Patient  
Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws, and disclosure is  
allowed only with my authorization except in limited circumstances described in Ellie  
Mental Health’s Privacy Notice.  
§ I can revoke this authorization at any time except to the extent that action has been taken  
in reliance on it. Ellie Mental Health’s Privacy Notice outlines the procedure for  
revocation. This authorization will expire in one year from the date I sign or unless I  
request an earlier expiration in writing.  
§ For disclosures other than for treatment, payment and healthcare operations purposes,  
treatment may not be conditioned on my agreement to sign and authorization (unless I am  
receiving care solely to create protected health information for disclosure to a third party)  
(45 CFR & 164.508 (b)(4)(III))  
§ Communications resulting from this authorization will reveal that I receive services at Ellie  
Mental Health.  
§ Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information  
from alcohol & drug abuse patient records. However, HIPAA requires Ellie Mental Health  
to notify me of the potential that information disclosed pursuant to this authorization  
might be re-disclosed by the recipient and is no longer protected by HIPAA.  
§ This authorization may be used by Ellie Mental Health owned or managed programs upon  
transfer of my care to them.

7. SIGNATURE

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

OR Authorized Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Representative’s Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative’s Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_